IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RICHARD M. ARMSTRONG – Director

LESLIE M. CLEMENT - Administrator
DIVISION OF MEDICAID
Post Office Box 83720
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October 10, 2007

CERTIFIED MAIL #: 7003 0500 0003 1967 0735

Kayleen Parke, Administrator
Downey Care Center, LLC
PO Box 344
Downey, ID 83234

Dear Ms. Parke:

Based on the complaint investigation, state licensure survey conducted by our staff at Downey Care Center LLC on **September 19, 2007,** we have determined that the facility failed to protect residents from inadequate care. Based on record review, observation, and interview, it was determined the facility failed to provide supervision which had the potential to affect 100 percent of the residents. The facility also failed to develop NSAs to include BMPs for 2 of 5 sampled residents (Residents #1 and #5). Further, the facility did not provide adequate assistance and monitoring of medications for 2 of 5 sampled residents (Residents #2 and #5).

This core issue deficiency substantially limits the capacity of Downey Care Center LLC to furnish services of an adequate level or quality to ensure that residents' health and safety are safe-guarded. The deficiency is described on the enclosed Statement of Deficiencies.

You have an opportunity to make corrections and thus avoid a potential enforcement action. Correction of this deficiency must be achieved by **November 3, 2007. We urge you to begin correction immediately.**

After you have studied the enclosed Statement of Deficiencies, please write a Plan of Correction by answering **each** of the following questions for **each** deficient practice:

- What corrective action(s) will be accomplished for those specific residents/personnel/areas found to have been affected by the deficient practice?
- How will you identify other residents/personnel/areas that may be affected by the same deficient practice and what corrective action(s) will be taken?
- What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?
- How will the corrective action(s) be monitored and how often will monitoring occur to ensure that the deficient practice will not recur (i.e., what quality assurance program will be put into place)?
- What date will the corrective action(s) be completed by?

Return the **signed** and **dated** Plan of Correction to us by **October 23, 2007,** and keep a copy for your records. Your license depends upon the corrections made and the evaluation of the Plan of Correction you develop.

In accordance with Informational Letter #2002-16 INFORMAL DISPUTE RESOLUTION (IDR) PROCESS, you have available the opportunity to question cited deficiencies through an informal dispute resolution process. If you disagree with the survey report findings, you may make a written request to the Chief of the Bureau of Facility Standards for a Level 1 IDR meeting. The request for the meeting must be made within ten (10) business days of receipt of the statement of deficiencies (**October 23, 2007**). The specific deficiencies for which the facility asks reconsideration must be included in the written request, as well as the reason for the request for reconsideration. The facility's request must include sufficient information for the Bureau of Facility Standards to determine the basis for the provider's appeal. If your request for informal dispute resolution is received after **October 23, 2007,** your request will not be granted.

Please bear in mind that non-core issue deficiencies were identified on the punch list, a copy of which was reviewed and left with you during the exit conference. The completed punch list form and accompanying proof of resolution (e.g., receipts, pictures, policy updates, etc.) are to be submitted to this office by **October 19, 2007**.

If, at the follow-up survey, it is found that the facility is not in compliance with the rules and standards for residential care or assisted living facilities, the Department will have no alternative but to initiate an enforcement action against the license held by Downey Care Center Llc.

Should you have any questions, or if we may be of assistance, please call our office at (208) 334-6626.

Sincerely,

Patty West-Deiss, MSW for

JAMIE SIMPSON, MBA, QMRP
Supervisor
Residential Community Care Program

JS/sc

Enclosure

c: Paula Gilbert, RN, Program Manager, Regional Medicaid Services, Region VI - DHW

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13R756	A. BUILDING _____ B. WING _____	09/19/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DOWNEY CARE CENTER LLC	351 E CENTER DOWNEY, ID 83234

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 000	Initial Comments The following deficiency was cited during the standard and complaint health care survey conducted at your residential care/assisted living facility. The surveyors conducting your standard and complaint survey were: Donna Henscheid, LSW Team Coordinator Health Facility Surveyor Sydnie Braithwaite, RN Health Facility Surveyor Definitions: ADL = Activity of Daily Living BMP = Behavior Management Plan HS = Hour of Sleep NSA = Negotiated Service Agreement O2 = Oxygen RN = Registered Nurse	R 000		
R 008	16.03.22.520 Protect Residents from Inadequate Care. The administrator must assure that policies and procedures are implemented to assure that all residents are free from inadequate care. This Rule is not met as evidenced by: Based on record review, observation, and interview, it was determined the facility failed to provide supervision which had the potential to affect 100 % of the residents. The facility also failed to develop NSAs to include BMPs for 2 of 5 sampled residents (Residents #1 and #5). Further, the facility did not provide adequate	R 008		

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R 008	Continued From page 1 assistance and monitoring of medications for 2 of 5 sampled residents (Residents # 2 and #5). I. Inadequate Care A. Supervision The facility roster/sample matrix dated 9/17/07 documented fifteen residents resided in the facility and five of them were identified with Alzheimer's/dementia diagnoses. On 9/17/07 at 1:15 p.m., the facility was observed to have a motion detector located in front of the main entrance which sounded when the surveyors walked into the facility. The surveyors entered the facility without anyone coming to check the alarm. Three residents were in the dayroom and no caregivers were in sight until one came out of a side door from the kitchen. It was a large building (remodeled school) with two long wings, one facing east and one facing west. There were exits on each wing. The east exit had a locked door with a key pad. The west end had double doors with a doorbell type alarm that sounded when the door was opened. A surveyor went out the west wing, the alarm sounded but no staff came to the door to see who had gone out. The north exit had a ramp approximately 12 to 15 feet long that led to the outside smoking area. A motion detector sounded as soon as someone started going down the ramp. The dining room area included two small rooms which were located towards the back (north side) of the building. The only area that could be seen from the kitchen or dining room area was the first part of the west hallway. None of the exits could be seen from the kitchen or dining areas. On 9/17/07 at 1:30 p.m., during the facility tour,	R 008		

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R 008	Continued From page 2 Resident #3 stated there were a couple of residents that "wander all the time." On 9/17/07 at 1:40 p.m., a caregiver stated they brought Resident #2 into the dining room later than the other residents because of her behaviors. Further, the caregiver stated that Resident #2 sat alone at the small table because she takes her spoon and hits it on the table and waves it around. The caregiver described Resident #2 as blind and unable to hear very well. On 9/18/07 between 8:30 a.m. and 9:30 a.m., two caregivers and a secretary were observed in the facility. The secretary was in an office located down the west hall past the ramp exit. Caregiver A was observed in the dining room and Caregiver B was assisting residents in their rooms with cares and also bringing them to the dining room as they were ready. The kitchen had three entrances which residents and staff were observed going in and out of several times. On 9/18/07 between 8:35 a.m. and 8:56 a.m., Caregiver A was passing medications and fixing breakfast for other residents. A random resident was observed to approach the caregiver four times, either asking to go out to smoke or to get his medications. The caregiver told him she would get to him as soon as possible. On 9/18/07 at 9:00 a.m., Resident #5 was directed to sit down at the back side of the table. She became angry because she wanted to sit at the end and not near Resident #1. Caregiver A was passing medications to other random residents and Resident # 5 had not been served her food. After a few minutes, Resident #5 was observed to get up from the table without using her walker and said she was going to find her	R 008		

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R 008	Continued From page 3 family. The caregiver told her to sit back down but did not assist her or remind her to use her walker. On 9/18/07 at 9:05 a.m., Resident #5 started getting up from the table again stating, "I'm going to look for my family." Caregiver A instructed her to sit down. On 9/18/07 at 9:07 a.m., a random resident entered the dining area for the fourth time requesting his medications. Caregiver A stated the resident was not ready to sit down because he needed his dentures put in. On 9/18/07 at 9:09 a.m., Resident #5 got up from the table again. Resident #5, Resident #1 and another random resident were left in the dining room unattended while the Caregiver A went to assist a random resident with his dentures. On 9/18/07 at 9:15 a.m., Resident #2 was observed sitting at a small table all alone with her back to the other residents in the dining room. She was observed to grab at the silverware and began to bang her knife on the table. Caregiver B took the knife from the resident, placed the other two pieces of silverware beyond her reach and left the area. The resident was then given a plastic cup containing a pink liquid which Caregiver A said was Ensure. The resident took a couple of drinks of the Ensure, began to bang the cup, spilling some of the Ensure on the table. The caregiver had left her alone at the table. On 9/18/07 at 9:19 a.m., Caregiver A gave Resident #2 a banana and took the cup of Ensure with her to the kitchen. The caregiver returned with a red plastic cup which the caregiver said contained Cream of Wheat. Caregiver A left the resident alone at the table. The resident was	R 008		

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R 008	Continued From page 4 observed to take a drink and then bang the cup on the table, spilling some of the contents. On 9/18/07 at 9:20 a.m., Resident #5 was asked to take her medications but she refused. She was asked again but told the caregiver she had already taken them. After a few minutes, the resident angrily took them. On 9/18/07 at 9:23 a.m., Resident #5 was observed opening the front entrance door. Caregiver B redirected her down the hall to her room. On 9/18/07 at 9:25 a.m., Caregiver A gave Resident #2 a green plastic cup which the caregiver stated contained Metamucil. Caregiver A left the resident unattended. After assisting another random resident with getting his meal, Caregiver A sat with Resident #2 to coax her to drink the Metamucil. The resident began to bang the green cup with the Metamucil on the table spilling some of the contents. The caregiver then offered the resident the cup of Cream of Wheat. The resident repeatedly tapped her fingers across the top of the table and into the spilled liquid. Caregiver A assisted Resident #2, alternating between cups of liquid. The resident continued to bang each of the cups on the table. Caregiver A left Resident #2 alone again to assist the same random resident who was requesting his medications and would not stay at the table. The caregiver returned, cleaned up the spilled liquid and offered the Resident #2 a drink of the Cream of Wheat. The caregiver took the cup away prior to the resident dumping it out on the table. On 9/18/07 at 9:45 a.m., two surveyors exited the north door located by the ramp and re-entered	R 008		

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R 008	Continued From page 5 the same door. The motion alarm sounded but no staff responded to the alarm. On 9/18/07 at 11:03 a.m., a visitor came to the dining room and told the Caregiver A, " You've got a lady walking outside." Caregiver A was observed to leave the dining room, where three residents were still eating, to assist Resident #5 back into the facility. On 9/18/07 at 11:10 a.m., Caregiver A confirmed she was not aware the resident had left the facility because she was busy in the dining room. On 9/18/07 at 11:15 a.m., Caregiver B stated she did not hear the alarms because she was assisting a random resident in the shower. This caregiver and the secretary confirmed that Resident #5 had been found outside the facility on two other occasions. On 9/18/07 at 11:30 a.m., the administrator stated only two staff were scheduled each morning and there was no set time for the breakfast meal, the residents were served as they came. The administrator also stated she had difficulty with scheduling because she recently had three staff members resign for various reasons. The administrator confirmed that the current alarm system may not adequately meet the facility needs and would be investigating different systems but stated, "it would be very expensive." On 9/18/07 at 11:30 a.m., Caregiver A stated, "We get breakfast ready around 6:00 a.m. and are finished around 10:30 a.m." Further, the caregiver stated, "Things aren't usually this chaotic but I got a late start this morning." This caregiver confirmed that Resident #2 should have	R 008		

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R 008	Continued From page 6 someone to sit with her to supervise her during meals. On 9/18/07 at 1:25 p.m., Caregiver A stated that one other resident was able to get a block away from the facility before being found by staff. The facility failed to provide supervision which had potential to affect 100% of the residents. Several residents, exhibiting significant behaviors in the dining room, were not being properly supervised by the two staff who were busy providing cares, preparing breakfast and passing medications. Resident #5, who had a diagnosis of dementia and a history of elopement, was unsupervised and eloped from the facility. B. Development of NSA to include BMP 1. Resident #5's record documented the resident was admitted to the facility on 10/23/06 with the following diagnoses: dementia, hypertension, atrial fibrillation, and congestive heart failure. An NSA dated 11/23/06 documented in the Behavior section that Resident #5 required "staff to watch to assure [resident's name] stays where she is supposed to." A nursing assessment dated 06/28/07 documented Resident #5 had poor short-term memory and also documented her behaviors as "agreeable." On 9/18/07 at 11:03 a.m., a visitor came to the dining room and told a caregiver, "You've got a lady walking outside." Caregiver A went outside to assist the resident back into the facility. On 9/18/07 at 11:15 a.m., Caregiver B and the	R 008		

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R 008	Continued From page 7 secretary confirmed that Resident #5 had eloped from the facility on two other occasions. Although staff had identified the resident had eloped from the facility on two other occasions, the NSA did not incude a BMP to guide staff on what interventions to put in place to keep her from leaving the facility unsupervised. 2. Review of Resident #1's record revealed the resident was admitted to the facility on 03/17/03 with a diagnosis of dementia. The resident's NSA documented the following under supervision: "[Resident ' s name] has been starting to do more wondering lately. We are watching closely. Family has been notified. " The "Resident Notes" included the following entries for the month of July 2007: 07/14/07 "... found her [Resident #1] in (a random resident's) room this AM. (A second random resident) said she had to shoo her from her room also. Starting to wander!" 07/15/07 "Restless! Wandering around if not on the couch." 07/16/07 "Up & down, back & forth from couch to table." 07/16/07 "On the couch, in the kitchen and back again!" 07/17/07 "Wandering quite a bit after lunch. Trying to take Resident #5's lunch." 07/17/07 "Wanted to be in the kitchen into everyone's food! Wandering a lot."	R 008		

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R 008	Continued From page 8 07/18/07 "Being quiet today. Here, there, everywhere." Entries in the Resident Notes log for the month of September 2007 included the following: 09/11/07 "Caught her trying to use resident's couch as a toilet." 09/13/07 "Up several times looking for her bed." 09/15/07 "Up & down looking at residents." 09/16/07 "After supper in and out of kitchen, then was in a random resident ' s room." On 09/17/07 at 4:25 p.m., Resident #1 was seen laying almost flat on her back in a recliner. A caregiver standing nearby was asked if this resident could get out of the recliner by herself. She replied, "No, I have to help her because she wanders." On 09/18/07 at 9:15 a.m., Residents #1 and #5 were sitting next to each other at the dining room table. A caregiver served cold cereal to both of them. The caregiver turned away and headed back towards the kitchen. Resident #1 was then observed to take a spoonful of cereal from Resident #5's bowl. Resident #5 said. "What's she (Resident #1) doing eating out of my dish?" On 09/18/07 at 11:08 a.m., Resident #1 was observed walking towards the facility's front door. She was heard to ask, "Can you open the door for me?" On 09/17/07 at 1:30 p.m. during a tour of the facility, a random resident stated, "She (Resident	R 008		

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R 008	Continued From page 9 #1) keeps staring at me. She came into my room one day and went through my crocheting. She tried to pee on a chair in my room." A second random resident stated, "There's a lady who wanders. She came into my room once and tried to use the chair for the bathroom." On 09/18/07 at 1:20 p.m., a caregiver confirmed Resident #1 had been wandering around the facility the last two months. She also stated the wandering behaviors had increased the last few weeks. Although Resident #1's NSA identified she had increased wandering behaviors, the resident's record did not inlcude a BMP to provide guidance to staff regarding what interventions to use to prevent her from infringing on the rights of other residents or to identify the potential for her to leave the facility unsupervised. The facility did not update the NSAs to include BMPs for Resident #1 and #5. There were no BMPs in place to direct staff on what interventions to use to manage the residents' behaviors nor were there behavior tracking systems in place to monitor the intensity, duration and frequency of those behaviors. C. Assistance and Monitoring of Medications 1. Resident #4's closed record documented the resident was admitted to the facility on 4/23/05 with diagnoses including the following: advanced senile dementia, chronic low back pain, osteoporosis, anxiety, chronic constipation, depression, and congestive heart failure. Resident #4's NSA dated 03/23/06 documented facility staff were to assist the resident with daily	R 008		

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R 008	Continued From page 10 medications. Vicodin/hydrocodone A letter dated 1/30/07 to the administrator from the facility RN was found in Resident #4's record. The letter documented hydrocodone was short 16 tablets. An outpatient medication list dated 2/27/06 documented the following: acetaminophen 500-Hydrocodone 5 mg tablet, take 1 to 2 tablets by mouth two (2) times a day if needed for pain. May cause drowsiness. Not more than for (4)grams of acetaminophen per day. Resident #4's May 2007 MAR dated 05/01/07 through 05/31/07 documented the following: Hydrocod/APAP 5/500 tab (mall) (Vicodin 5/500 tab) Take one tablet by mouth two (2) times daily. The MAR documented that Vicodin had been given routinely three times each day instead of two times a day as ordered by the physician. Resident #4's June 2007 MAR dated 06/01/07 through 06/30/07 documented the following: Hydrocod/APAP 5/500 Tab (mall) (Vicodin 5/500 TAB) Take one tablet by mouth twice daily. The MAR documented that Vicodin had been given routinely three times each day, excluding one bedtime dose. On 9/19/07 at 10:00 a.m., the administrator left a note and a copy of an order dated 7/16/07 to explain why the Vicodin was given three times a day instead of two times as ordered by the	R 008		

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R 008	Continued From page 11 physician. The note documented, "here is the order - every 6 - 8 hours - equals the 3x's a day she was getting." The order that was attached to the note was for methadone and not the Vicodin (which was the medication in question.) Methadone On 9/19/07 at 10:00 a.m., the administrator left a copy of an order dated 7/16/07 for methadone 20 mg # 60, take 1/2 tab every 6-8 hours for pain. Neither the July 2007 nor the August 2007 MARs documented the methadone was given. The facility did not monitor Resident #4's use of medications. Missing narcotic medications were not accounted for, medications were ordered but not given and medications were given which were not consistent with the physician's order. There was no documentation by the administrator or the facility nurse that an investigation into the missing medications had been done. 2. Resident #2 was admitted to the facility on 8/07/05 with diagnoses including the following: senile dementia, osteoporosis, and congestive heart failure. A physician order dated 2/7/06 documented the following order: O2 at 2 Liters. A hospice Medication Profile and Teaching Form dated 6/19/07 documented O2 at 2.5 liters per nasal cannula, on at HS and off in day time, for sleep apnea. A hospice telephone physician order dated 7/18/07 documented O2 at 2 liters per nasal cannula continuously 24 hours per day for the diagnosis of hypoxia. The order was not signed	R 008		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13R756	A. BUILDING _____ B. WING _____	09/19/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DOWNEY CARE CENTER LLC	351 E CENTER DOWNEY, ID 83234

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 008	Continued From page 12 by a physician. A staff communication note dated 9/5/07 documented the hospice nurse had been at the facility, listened to the resident's lungs and "bumped" her oxygen up to 4 liters. On 9/17/07 at 1:20 p.m. the resident was observed asleep in the dayroom recliner with oxygen per nasal cannula. The oxygen concentrator was set at 3 liters. On 9/18/07 at 12:05 p.m., the resident was observed in her bed with oxygen per nasal cannula, the oxygen concentrator was set between 3 and 3.5 liters. On 9/19/07 at 10:10 a.m., the Resident #2 was observed in the dayroom laying in the recliner with oxygen per nasal cannula. The concentrator was set between 3 and 3.5 liters. On 9/18/07 at 12:07 p.m., the hospice nurse confirmed she had requested the oxygen liter flow increase to 4 liters. The hospice nurse also stated she had made the change over two weeks ago but the physician had not signed the order because she saved them for him to sign all at once. Further, the hospice nurse stated she had not communicated the oxygen change to the facility RN. On 9/19/07 at 10:10 a.m., a caregiver stated Resident #2's oxygen flow should be set at 3 liters. The caregiver stated she thought the hospice nurse had made changes to the liter flow a couple of weeks ago but was uncertain where this information could be found. The facility did not monitor Resident #2's use of	R 008		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13R756	A. BUILDING _____ B. WING _____	09/19/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DOWNEY CARE CENTER LLC	351 E CENTER DOWNEY, ID 83234

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 008	Continued From page 13 oxygen and staff were assisting with oxygen use without any clear direction from the facility RN or hospice agency nurse. The facility failed to provide sufficient supervision to assure residents' health, safety and comfort was provided for at all times, affecting potentially 100% of the residents in the facility. The facility failed to develop the NSA to include a BMP for Residents #1 and #5 to direct staff on appropriate interventions and safety precautions. Additionally, the facility failed to provide assistance and monitoring of medications for Residents #2 and #4. These failures resulted in inadequate care.	R 008		

IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RICHARD M. ARMSTRONG – Director

LESLIE M. CLEMENT - Administrator
DIVISION OF MEDICAID
Post Office Box 83720
Boise, Idaho 83720-0036
PHONE: (208) 334-5747
FAX: (208) 364-1811

October 10, 2007

Kayleen Parke, Administrator
Downey Care Center, LLC
PO Box 344
Downey, ID 83234

Dear Ms. Parke:

On September 19, 2007, a complaint investigation survey was conducted at Downey Care Center LLC. The survey was conducted by Sydnie Braithwaite, RN and Donna Henscheid, LSW. This report outlines the findings of our investigation.

Complaint # ID00003141

Allegation #1: A resident received Hydrocodone routinely instead of "as needed" as ordered by the physician.

Findings: The identified resident's record contained a physicians order for Lortab 7.5/500 #100, take one or two tablets every 8 to 12 hours as needed.

The identified resident's Controlled Drug Record for July 2007 and August 2007 documented the caregivers had given only two tablets when requested by the resident for pain.

On September 17, 2007 at 4:20 p.m., the identified resident stated she requested the hydrocodone (Loretab) occasionally for back pain.

On September 18, 2007 at 1:40 p.m., the administrator stated that the Hydrocodone was ordered for the identified resident for low back pain which she generally takes at night. The administrator stated the resident was alert and oriented and able to request one or two tablets of the Hydrocodone as she needed.

Conclusion: Unsubstantiated. However, the facility was cited for monitoring of medicatations due to other problems identified during the investigation. The facility was required to submit a plan of correction.

Allegation#2:	During June and July a resident was given more Oxycontin than was prescribed by the physician.
Findings:	Unsubstantiated. Based on observation, interview and record review it could not be determined if the resident received more Oxycontin than prescribed by the physician. On September 18, 2007 the resident's record was reviewed and documentation indicated the order for Oxycontin had been discontinued and switched to Vicodin on January 2, 2007 per recommendations of the nurse practioner. The resident's MARs for May, June and July 2007 did not document that Oxycontin had been given during this timeframe.
Conclusion:	Due to other problems identified with the resident's medications, the facility was cited at 16.03.22.520 for inadequate care related to assistance and monitoring of medication. The facility was required to submit a plan of correction.

If you have questions or concerns regarding our visit, please call us at (208) 334-6626. Thank you for the courtesy and cooperation you and your staff extended to us while we conducted our investigation.

Sincerely,

Donna Henscheid

DONNA HENSCHEID, LSW
Team Leader
Health Facility Surveyor
Residential Community Care Program

DH/sc

c: Jamie Simpson, MBA, QMRP, Supervisor, Residential Community Care Program
Donna Henscheid, LSW, Health Facility Surveyor

IDAHO DEPARTMENT OF HEALTH & WELFARE

BUREAU OF FACILITY STANDARDS
P.O. Box 83720
Boise, ID 83720-0036
(208) 334-6626 fax: (208) 364-1888

ASSISTED LIVING
Non-Core Issues Punch List

Facility Name	Physical Address	Phone Number
Downey Care Center	351 E Center	208-897-5083
Administrator	**City**	**ZIP Code**
Kayleen Parke	Downey	83234
Survey Team Leader	**Survey Type**	**Survey Date**
Donna Henscheid	Standard/Complaint	9/19/07

NON-CORE ISSUES

ITEM #	RULE # 16.03.22	DESCRIPTION	DATE RESOLVED	BFS USE
1	151.01-151.03	The facility did not provide an activity program to promote residents' highest potential for living.		
2	321	5 of 5 residents did not receive an updated Admission agreement which included a 30 day discharge notice.		
3	250.14	The facility did not provide a secure interior environment for Residents with dementia		
4	300.02	The facility RN was not notified of residents' health changes, i.e.: falls.		
5	305.09	The facility RN did not complete an assessment for Random Resident's use of side rails.		
6	310.d	Facility staff did not assist with medications consistent with the Board of Nursing requirements, i.e.: medication cart left unlocked when leaving area.		
7	310.f.	Facility staff did not observe each resident take their medication.		
8	320.02.p.	Resident #2's NSA did not include services being		

Response Required Date	Signature of Facility Representative	Date Signed
10/19/07	Julie Anderson	9-19-07

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ASSISTED LIVING
Non-Core Issues
Punch List

Facility Name	Physical Address	Phone Number
Downey Care Center	351 E. Center	208-897-5683
Administrator	**City**	**ZIP Code**
Kayleen Parke	Downey	83234
Survey Team Leader	**Survey Type**	**Survey Date**
Donna Henscheid	Standard / Complaint	9/19/07

NON-CORE ISSUES

ITEM #	RULE # 16.03.22	DESCRIPTION	DATE RESOLVED	BFS USE
8	Cond. 320 02.p	provided by hospice services		
9	450	The facility did not meet the standards of the Idaho Food Code. See food inspection report.		
10	451.01.c	Resident #2 did not have an MD order for pureed diet.		
11	460.02.b	The facility did not ensure there was less than fourteen hours between meals. i.e: residents served breakfast 15½ hrs after the dinner meal the day before.		
12	600.06.b	The facility did not provide at least one staff at night with CPR training.		
13	625.01	1 of 3 staff members did not have documentation of orientation (16 hrs)		
14	630.01	3 of 3 staff members did not have dementia training		
15	640	1 of 3 staff member did not have continued education credits.		
16	650.02	The NSA/QAI Combined form the facility was using		

Response Required Date	Signature of Facility Representative	Date Signed
10/19/07	Julie Anderson	9-19-07

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ASSISTED LIVING
Non-Core Issues Punch List

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Administrator	**City**	**ZIP Code**
Kayleen Parke	Downey	83234
Survey Team Leader	**Survey Type**	**Survey Date**
Donna Henscheid	Standard / Complaint	9/19/07

NON-CORE ISSUES

ITEM #	RULE # 16.03.22	DESCRIPTION	DATE RESOLVED	BFS USE
16	650.02 Cont.	- did not include medical diagnoses or completed background information.		
17.	711.08	The facility did not ensure care notes were completed by outside service agencies and included in residents' records.		
18	711.08.e.	The facility did not notify the RN of changes in residents' physical or mental status		
19	730.01.g.	3 of 3 staff did not have finalized results of their criminal background checks.		
20.	730.01.h	The facility RN did not provide delegation to unlicensed staff for: Blood sugars, O2 use, vital signs, positioning, etc.		
21	310.01	The facility used bulk over-the-counter medications without a variance. (House supply)		

Response Required Date	Signature of Facility Representative	Date Signed
10/19/07	Julie Anderson	9-19-07